TEXAS DEPARTMENT OF INSURANCE
**Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)**
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# MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

## *GENERAL INFORMATION*

**Requestor Name**
James Weiss, M.D.

**Respondent Name**
Atlantic Specialty Insurance Company

**MFDR Tracking Number**
M4-17-0915-01

**Carrier's Austin Representative**
Box Number 29

**MFDR Date Received**
December 5, 2015

## *REQUESTOR'S POSITION SUMMARY*

**Requestor's Position Summary:** "DESIGNATED DOCTOR EXAMINATION INCORRECT REDUCTION/PARTIAL PAY"

**Amount in Dispute:** $150.00

## *RESPONDENT'S POSITION SUMMARY*

**Respondent's Position Summary:** Submitted documentation does not include a position statement from the respondent.

## *SUMMARY OF FINDINGS*

| Dates of Service | Disputed Services | Amount In Dispute | Amount Due |
|---|---|---|---|
| February 23, 2016 | Designated Doctor Examination | $150.00 | $0.00 |

## *FINDINGS AND DECISION*

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

**Background**

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - W3 – Request for reconsideration
   - BL – This bill is a reconsideration of a previously reviewed bill, allowance amounts do not reflect previous payments.

**Issues**

1. Did Atlantic Specialty Insurance Company (Atlantic Specialty) respond to the medical fee dispute?
2. Is James Weiss, M.D. eligible for an additional reimbursement of $150.00 for the service in question?

**Findings**

1. The Austin carrier representative for Atlantic Specialty is Pappas & Suchma, P.C. Pappas & Suchma, P.C. acknowledged receipt of the copy of this medical fee dispute on December 9, 2016.

   28 Texas Administrative Code §133.307 states, in relevant part:

   (d) Responses. Responses to a request for MFDR shall be legible and submitted to the division and to the requestor in the form and manner prescribed by the division.
   (1) Timeliness. The response will be deemed timely if received by the division via mail service, personal delivery, or facsimile **within 14 calendar days after the date the respondent received the copy of the requestor's dispute** [emphasis added]. If the division does not receive the response information within 14 calendar days of the dispute notification, then the division may base its decision on the available information.

   Review of the documentation finds that no response has been received on behalf of Atlantic Specialty from Pappas & Suchma, P.C. to date. The division concludes that Atlantic Specialty failed to respond within the timeframe required by §133.307(d)(1). For that reason the division will base its decision on the information available.

2. James Weiss, M.D. is seeking a reimbursement of $150.00 for a designated doctor examination, represented by procedure code 99456-W5-WP, performed on February 23, 2016. Review of the submitted documentation finds an explanation of benefits dated May 20, 2016 indicating a reimbursement of $150.00 for the service in question. The division concludes that Dr. Weiss is not eligible for an additional reimbursement of the service in question.

**Conclusion**

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

***ORDER***

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 additional reimbursement for the services in dispute.

**Authorized Signature**

| | Laurie Garnes | March 31, 2017 |
|---|---|---|
| Signature | Medical Fee Dispute Resolution Officer | Date |

## *YOUR RIGHT TO APPEAL*

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

**Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812**.